MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03392

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (In this place): 12 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville, State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 14 Ridout Street

3. NAME OF DECEASED (Type or Print): (First) Roswell (Middle) Baden (Last)

4. DATE OF DEATH: (Month) 4/14/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 1/4/04

9. AGE last birthday: 45 yrs. — If under 1 year Months, Days; If under 24 hrs. Hours, Min.: ********

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas Baden

14. MOTHER'S MAIDEN NAME: Heddie Reed

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): **********

16. SOCIAL SECURITY NO.: **********

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Gumma of the Cerebellum — Interval between onset and death: known since 4/3/49

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b):

(c): Psychosis due to Gumma of the Cerebellum — known to us since 4/3/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **********

19b. MAJOR FINDINGS OF OPERATION: **********

20. AUTOPSY? Yes [X] No [ ]

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): **********

PLACE (Home, farm, factory, street, office bldg., etc.): **********

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): **********

INJURY OCCURRED While at Work [ ] Not While At work [ ]

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/3/49, 19..., to 4/14/49, 19..., that I last saw the deceased alive on 4/14/49, 19..., and that death occurred at 11:45 A.m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) M.D.

ADDRESS: Crownsville, Maryland

DATE SIGNED: 4/14/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: April 18, 1949

NAME OF CEMETERY OR CREMATORY: Brewer Hill

LOCATION (City, town, or county): Annapolis (State): Md.

DATE REC'D BY LOCAL REG.: April 18, 1949

REGISTRAR'S SIGNATURE: E. F. Joyce L. Reg

24. FUNERAL DIRECTOR: Mrs Charles B. Hicks

ADDRESS: 145 northwest Annapolis Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 03393

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY: Anne Arundel County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Balt. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 1 yr. 30 days	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): not known

3. NAME OF DECEASED (Type or Print)	(First) Frank	(Middle) n	(Last) Bell	4. DATE OF DEATH (Month) 4/11/49 (Day) (Year) 19
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: not known	9. AGE last birthday: 1888 61(?) yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U S.	
13. FATHER'S NAME: John Bell		14. MOTHER'S MAIDEN NAME: Rachel Allen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
025 Immediate cause	(a) General Paresis	known to us since 3/6/48
Antecedent cause(s)		
30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/6/49, 19....., to 4/11/49, 19....., that I last saw the deceased alive on 4/11/49, 19....., and that death occurred at 10:05 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marycuster M.D.		Crownsville, Maryland	4/12/49

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: 4/13/49	NAME OF CEMETERY OR CREMATORY: Crownsville	LOCATION (City, town, or county) (State): Crownsville, Md.
DATE REC'D BY LOCAL REG.: April 13, 1949	REGISTRAR'S SIGNATURE: E. F. Joyce L. Reg	24. FUNERAL DIRECTOR: Johnson & Jenkins Wash. D.C.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03394

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45

1. PLACE OF DEATH:

County: A.A.

City or town: Pasadena (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Brooklyn Park (If outside city or town limits, write RURAL and give nearest town)

Street No.: 112 Third Avenue (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Frederick Bengles dorf

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Lula M. Lewis

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/28/1880

8. AGE: Years	Months	Days	If less than one day
68	9	25	hrs. min.

9. Birthplace: Hartford County, Maryland (Town, county, and state)

10. Usual occupation: Balto. Transit Co. (Ret.)

11. Industry or business

FATHER 12. Name: Charles

13. Birthplace: Germany

MOTHER 14. Maiden name: Elizabeth ?

15. Birthplace: ?

16. Informant: Family

Address: Same

17. B (Burial, cremation, or removal. Which?) Date thereof 4/27/49 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn, Maryland

18. Funeral director: James L. McCauley

Address: 130 East Fort Avenue

19. 4/26 19 49 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 23 19 49 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~19~~ to April 23 19 49

and that I last saw h alive on Did not see him alive 19

Immediate cause of death	DURATION
Acute Myocardial failure	Immediate
Due to: Coronary thrombosis	Unknown
Due to: Coronary sclerosis 420.1	Unknown
Other conditions: Unknown 940	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) —

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: A. Gaalaas M.D. M. D. or other

Address: Green Gables Pasadena, Md. Date signed: Apr. 23, 1949

MARYLAND STATE DEPARTMENT OF HEALTH

03395

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
LENGTH OF STAY (In this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 6207 Lee Place, N.E.

3. NAME OF DECEASED (Type or Print) (First) Henry (Middle) (Last) Black

4. DATE OF DEATH (Month) Apr. (Day) 16 (Year) 1949

5. SEX male | 6. COLOR OR RACE negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH Sept 14, 1900 | 9. AGE last birthday 49 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY Truck Driver | 11. BIRTHPLACE (State or foreign country) Johnson, S.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Warren Black | 14. MOTHER'S MAIDEN NAME E[illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. 578-10-6052 | 17. INFORMANT James Black (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary occlusion — Sudden

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from....., 19....., to....., 19.....,~~ made a Postmortem Examination April 16, 1949 ~~that I last saw the deceased alive on....., 19.....,~~ and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Claffy M.D. Deputy Medical Examiner Annapolis Maryland 4-16-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 4/18/49 | NAME OF CEMETERY OR CREMATORY Washington | LOCATION (City, town, or county) Washington (State) D.C.

DATE REC'D BY LOCAL REG. 4/16/49 | REGISTRAR'S SIGNATURE J.M. Clayton Dep Asst | 24. FUNERAL DIRECTOR ADDRESS Rollins Funeral Home 4339 Hunt Pl. N.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

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03396

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
LENGTH OF STAY (in this place) 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 525 MANOR Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE.
STREET ADDRESS (If rural give location) 525 MANOR ROAD.

3. NAME OF DECEASED (Type or Print) (First) MARJORIE (Middle) ELLEN (Last) BLOIS

4. DATE OF DEATH (Month) APRIL (Day) 11, (Year) 1949

5. SEX Female
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH JUNE 15, 1885
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) Holbrook, MASS.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME CHARLES A. BLANDIN
14. MOTHER'S MAIDEN NAME SARAH E. Blois.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT GEORGE W. BLOIS, 525 MANOR Road GLEN BURNIE, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Thrombosis	20 hrs.
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) General Arterio-Sclerosis	3 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1946, to April 11, 1949, that I last saw the deceased alive on 4/10, 1949, and that death occurred at 1 A.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faubert R.W. (Degree or title) ADDRESS Glen Burnie DATE SIGNED April 12-1949

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF April 14, 1949
NAME OF CEMETERY OR CREMATORY GLEN HAVEN Memo. PK
LOCATION (City, town, or county) GLEN BURNIE (State) Md.

DATE REC'D BY LOCAL REG. 4/14/49
REGISTRAR'S SIGNATURE L. J. De Allen
24. FUNERAL DIRECTOR Thomas W. Snughton ADDRESS Glen Burnie, Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03397

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS 99 Calvert St (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Adell (Middle) — (Last) Boothe
4. DATE OF DEATH: (Month) 4 (Day) 10 (Year) 1949

5. SEX: Female | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: 1-1-1902 | 9. AGE last birthday: 47 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress | 10b. KIND OF BUSINESS OR INDUSTRY: Hotel | 11. BIRTHPLACE (State or foreign country): Annapolis Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Simms | 14. MOTHER'S MAIDEN NAME: Annie Simms

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. 216-22-3545 | 17. INFORMANT: Charles H. P. Boothe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

150 Immediate cause (a) Carcinoma of Esophagus

Antecedent cause(s)

460 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION: None | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY No | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) No m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2-49, 19..., to 4-10-49, 19..., that I last saw the deceased alive on 4-10-49, 19..., and that death occurred at 3:10 P.M., from the causes and on the date stated above.

SIGNATURE Gordon K. Johnson (Degree or title) M.D. ADDRESS 40 Northwest Street DATE SIGNED 4-10-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 4-13-49 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. April 12, 1949 | REGISTRAR'S SIGNATURE Mary T. Branch

24. FUNERAL DIRECTOR William Reese III - 108 Washington ADDRESS Annapolis, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03398

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Neck- near Annapolis, Md.
STREET ADDRESS (If rural, give location) Annapolis Neck- Rout#3

3. NAME OF DECEASED (Type or Print) (First) Jessie (Middle) (Last) Brashears

4. DATE OF DEATH (Month) 4 (Day) 17 (Year) 1949

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 1872
9. AGE last birthday 77 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Annapolis Neck, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Brashears
14. MOTHER'S MAIDEN NAME Catherine Pinkney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Prisilla Brashears

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

610 Immediate cause (a) Pulmonary Embolism

137a Antecedent cause(s) (b) Prostatic Hypertrophy

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 4/17/49
19b. MAJOR FINDINGS OF OPERATION Enlarged Prostate
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2/49 19..., to 4/17, 1949, that I last saw the deceased alive on 4/17/49, 19..., and that death occurred at 6.30 A.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Albert L. Anderson MD ADDRESS 144 Mitgave - Annapolis, Md DATE SIGNED 4/19/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE April 21, 1949
NAME OF CEMETERY OR CREMATORY Annapolis Neck Cemetery
LOCATION (City, town, or county) Annapolis Neck, (State) Md.

DATE REC'D BY LOCAL REG. April 21, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Mrs. Charles E. Hicks- ADDRESS 43-45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03399

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Spell every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 7 Days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood, Md. near Annapolis; STREET ADDRESS (If rural, give location) Harwood, Md. near Annapolis

3. NAME OF DECEASED (Type or Print): (First) Frances (Middle) (Last) Brown

4. DATE OF DEATH: (Month) 4 (Day) 21 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: I 89I Apr.

9. AGE last birthday: 58 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Burns

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Amanda Moreland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ac. Lobar Pneumonia, Rt. Lung — Interval between onset and death: 2 wks.

331 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral hemorrhage — 3 mos. ca.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis C.V. disease & decompensation — 2 wks.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/14, 1949, to 4/21, 1949, that I last saw the deceased alive on 4/20, 1949, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Maurice F. Klavans — ADDRESS Annapolis, Md — DATE SIGNED 4/23/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE 4-24-1949 | NAME OF CEMETERY OR CREMATORY: Friendship Cemetery | LOCATION (City, town, or county) (State): Friendship A.A.Co. Md.

DATE REC'D BY LOCAL REG. April 23, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR ADDRESS: Mrs. Charles E. Hicks- 43-45 Northwest St.

RECEIVED
APR 26 1949
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

03490

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS. — LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: EMERGENCY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: A.A Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: EDGEWATER, MD.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ELIZABETH (Last) CADLE

4. DATE OF DEATH: (Month) APRIL (Day) 16 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify):

8. DATE OF BIRTH: 1878

9. AGE last birthday: 70 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES DAVIS

14. MOTHER'S MAIDEN NAME: MELLECENT REDMOUD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: MRS. HAROLD PRICE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — 1/4 hr.

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

93d (b) arteriosclerotic cardiovascular disease & angina. — 4-5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, ferm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Dey) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1944, to Apr. 17, 1949, that I last saw the deceased alive on Apr. 17, 1949, and that death occurred at 9:00 P.m., from the causes and on the date stated above.

SIGNATURE: S. Borrough (Degree or title): M.D. ADDRESS: Annapolis Md DATE SIGNED: 4/18/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): DATE: 4/14/49 NAME OF CEMETERY OR CREMATORY: EDWARDS CHAPEL LOCATION (City, town, or county): ANNAPOLIS, (State): MD.

DATE REC'D BY LOCAL REG.: April 19, 1949 REGISTRAR'S SIGNATURE: [signature] 24. FUNERAL DIRECTOR: JOHN M. TAYLOR-SON ADDRESS: ANNAPOLIS, MD.

RECEIVED
APR 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03401

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS NURSING HOME 1312 WEST St

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural, give location) 57 STATE CIRCLE

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) HALLAM (Last) CLAUDE

4. DATE OF DEATH: (Month) 4 (Day) 4 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 3-31-1862

9. AGE last birthday: 86 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET LAWYER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): ANNAPOLIS MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ABRAM CLAUDE

14. MOTHER'S MAIDEN NAME: RACHEL TUCK CLAUDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk. (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: MRS DOUGLAS HOWARD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592 Immediate cause (a) Myocarditis and Myocardial Insufficiency Chr. — Interval: Several years

131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arteriosclerosis — Interval: years

(c) Chr. Interstitial Nephritis — Interval: 8 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1-, 1949, to 4-4, 1949, that I last saw the deceased alive on 3-4, 1949, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George E. Beall M.D. ADDRESS Annapolis Md DATE SIGNED 4-5-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 4-5-49 | NAME OF CEMETERY OR CREMATORY St Annes | LOCATION (City, town, or county) (State) ANNAPOLIS MD

DATE REC'D BY LOCAL REG. April 5, 1949 | REGISTRAR'S SIGNATURE W. D. Branch | 24. FUNERAL DIRECTOR John M. Taylor-Son | ADDRESS Annapolis Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03402

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Annapolis; STREET ADDRESS (If rural give location) Skidmore

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Colbert (Last)

4. DATE OF DEATH: (Month) April (Day) 23, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: March, 1871

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Hagothy, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Horace Walker

14. MOTHER'S MAIDEN NAME: Henretta Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Adley Colbert

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Thrombosis

Antecedent cause(s) (b) Arteriosclerotic Vascular Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Senility.

532

831

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 15, 19 48, to April 23 19 49, that I last saw the deceased alive on Apr. 22, 19 49, and that death occurred at 8 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Maurice F. Klaware, MD Annapolis, Md 4/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: April 26 1949

NAME OF CEMETERY OR CREMATORY: Broadneck

LOCATION (City, town, or county) (State): Skidmore, Md.

DATE REC'D BY LOCAL REG.: April 26, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: J. B. Johnson, ADDRESS: Annapolis, Md.

RECEIVED
APR 27 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03403

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pantuxent, Odenton
LENGTH OF STAY (in this place) 8 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural, give location) Pantuxent

3. NAME OF DECEASED (Type or Print) (First) Barry (Middle) Wilson (Last) Cornell

4. DATE OF DEATH (Month) Apr. (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH July 13, 1948
9. AGE last birthday ___ yrs. If under 1 year: Months 8, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Franklin Cornell
14. MOTHER'S MAIDEN NAME Ethel Virginia Crawford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT George F. Cornell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxiation

921.0 Antecedent cause(s)

195d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Regurgitation of vomitus

(c) Accidental

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home
(CITY OR TOWN) Odenton (Pantuxent) (COUNTY) A. A. (STATE) Md.
TIME OF INJURY (Month) Apr. (Day) 8 (Year) 1949 (Hour) about 5 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? vomited while taking milk formula

22. I hereby certify that I ~~attended the deceased from ..... 19.....~~ made a Postmortem Examination ~~to~~ Apr. 8, 1949, ~~that I last saw the deceased alive on ..... 19.....~~, and that death occurred ~~at~~ between 5 and 7 A.m., from the causes and on the date stated above.

SIGNATURE John M. Claffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Maryland DATE SIGNED 4/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-10-49
NAME OF CEMETERY OR CREMATORY Trinity Methodist Church yd
LOCATION (City, town, or county) Pantuxent (State) Odenton Md. P.O.

DATE REC'D BY LOCAL REG. 4/10/49
REGISTRAR'S SIGNATURE [signature] L. J. DeAlba
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03404

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; MARYLAND; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Langley Field; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Earl (Middle) H (Last) Cunningham

4. DATE OF DEATH: (Month) Apr. (Day) 29 (Year) 1949

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: about 1930

9. AGE last birthday: 19 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER (CPL.)

10b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

11. BIRTHPLACE (State or foreign country): Hampton. Va

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: John Wesley Cunningham

14. MOTHER'S MAIDEN NAME: Vera Gregory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (819.5)	(a) Fracture of Skull	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (170c)	(b) Hematoma	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY U.S. Route #301

(CITY OR TOWN) near Millersville (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) Apr. (Day) 28 (Year) 1949 (Hour) 11 AM ☐ PM ☐

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Automobile Collision

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Cathey (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 4/29/49

23. BURIAL, CREMATION, REMOVAL (Specify): Removal

DATE THEREOF 29 Apr 49

NAME OF CEMETERY OR CREMATORY Unknown

LOCATION (City, town, or county) Hampton, Va. (State)

DATE REC'D BY LOCAL REG. 29 Apr 1949

REGISTRAR'S SIGNATURE E. K. BURNSIDE, CAPT., MSC

24. FUNERAL DIRECTOR Lilly & Zeiler Inc ADDRESS Baltimore, Md.

RECEIVED
MAY 9 1949
BUREAU V. S.

Evidence for change of age is on :

FILM No. G 120 MAY 4 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03405

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 3 mos. 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 904 S. Sharp Street

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) (Last) Davis
4. DATE OF DEATH (Month) 4/21/49 (Day) (Year) 19

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) separated
8. DATE OF BIRTH 3/18/15
9. AGE last birthday ~~33~~ 34 yrs. If under 1 year ~~Months Days~~ If under 24 hrs. ~~Hours Min.~~

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Augustus Davis
14. MOTHER'S MAIDEN NAME Edith (last name not known)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
025 Immediate cause	(a) General Paresis	known since 1/12/49
30 b Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED ~~While~~ Work ☐ ~~Not While~~ At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/12/49, 19....., to 4/21/49, 19....., that I last saw the deceased alive on 4/21/49, 19....., and that death occurred at 8:00 P.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Marcuston M.D. (Degree or title)
ADDRESS Crownsville State Hospital
DATE SIGNED 4/21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE April 27, 1949
NAME OF CEMETERY OR CREMATORY Mt. Auburn
LOCATION (City, town, or county) Balto (State) Md.

DATE REC'D BY LOCAL REG. 4/25/49
REGISTRAR'S SIGNATURE S.W. Hedrick Dm
24. FUNERAL DIRECTOR James A. Hayes
ADDRESS 142 W. Hill St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03406

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS — "

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print): (First) Ella (Middle) Adelaide (Last) Disney

4. DATE OF DEATH: (Month) April (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan 8 1889

9. AGE last birthday: 60 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Odenton, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Phillip Disney

14. MOTHER'S MAIDEN NAME: Mary Virginia Watts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Leonard J. Disney - Husband

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

421.1 **Immediate cause** (a) Aortic stenosis - Cause Undetermined — INTERVAL BETWEEN ONSET AND DEATH: 2 years

Antecedent cause(s)

92a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Auricular Fibrillation, Cardiac Decompensation

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to April 15, 1949, that I last saw the deceased alive on April 14, 1949, and that death occurred at 4:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Edward J. Merritt M.D. — Cambrills — April 15, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 4/18/49 | NAME OF CEMETERY OR CREMATORY: Nichols Memorial | LOCATION (City, town, or county) (State): Odenton A.A.Co. Md.

DATE REC'D BY LOCAL REG. April 16 1949 | REGISTRAR'S SIGNATURE: R.W. | 24. FUNERAL DIRECTOR: Wm Cook Inc. | ADDRESS: 1217 St. Paul St.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03407

Reg. Dist. No. 2 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Near Glen Burnie. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Glen Burnie. | LENGTH OF STAY (in this place) all his life.
HOSPITAL OR INSTITUTION OR STREET ADDRESS no

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Brooklyn R.F.D. 9. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same.
STREET ADDRESS (If rural give location) Near Rural.

3. NAME OF DECEASED (Type or Print): (First) Ida (Middle) Claudine. (Last) Disney.
4. DATE OF DEATH: (Month) April (Day) 21. (Year) 1949

5. SEX: Female.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 18, 1878
9. AGE last birthday: 71 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Montgomery Co. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Isaac Newton Shipley.
14. MOTHER'S MAIDEN NAME: Martha Jane Pyles.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Hiram Disney.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.1 Immediate cause	(a) Cerebral Hemorrhage	6 days
Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio. Vascular Disease	5 year.
	(c) —	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None | 19b. MAJOR FINDINGS OF OPERATION: — | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — | (CITY OR TOWN) — | (COUNTY) — | (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: — | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Jan., 1945, to April 21, 1949, that I last saw the deceased alive on April 20, 1949, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
James S. Bellenghy M.D. | 108 Central Ave. Glen Burnie Md | April 21. 1949

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE: April 23, 1949 | NAME OF CEMETERY OR CREMATORY: Meadowridge Cem. | LOCATION (City, town, or county) (State): Howard Co. Md.

DATE REC'D BY LOCAL REG.: 4/22/49 | REGISTRAR'S SIGNATURE: A. W. Hedrick | 24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS | ADDRESS: Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03408

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie. Md. LENGTH OF STAY (in this place) All his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 - 3rd Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Anne Arundel COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie.
STREET ADDRESS (If rural give location) 108 - 3rd Ave

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Albert	Herman	Dogge.	April	25	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male.	White.	Married	May 13, 1889.	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk	Military Service Home.	Baltimore. Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Albert H. Dogge.	Anna Becker.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Not. Served.			Mrs. A. H. Dogge.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Acute Dilatation of the Heart	Immediate.
93d Antecedent cause(s). Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-Vascular Disease.	5 years
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While at work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan., 1945, to April 24, 1949, that I last saw the deceased alive on April 14, 1949, and that death occurred at 5 20 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
James S. Bielinski. M.D.		108 Central Ave. Glen Burnie. Md.	4/27/49.

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 28, 1949	Cedar Hill	Glen Burnie, Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/26/49	L. J. Dallas	Thomas D. Singleton	Glen Burnie Md.

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21

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) Dead on arrival
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 21
STREET ADDRESS (If rural, give location) 392 Edgewater Apts.

3. NAME OF DECEASED (Type or Print) (First) Robert (Middle) Stephen (Last) Dornicak

4. DATE OF DEATH (Month) Apr. (Day) 6 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —
8. DATE OF BIRTH 10/6/46
9. AGE last birthday 2 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm. Dornicak
14. MOTHER'S MAIDEN NAME Hannah Fischer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hannah Shea

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s)

183 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spr Creek (CITY OR TOWN) Annapolis (COUNTY) Anne Arundel (STATE) Md.
TIME OF INJURY (Month) Apr. (Day) 6, (Year) 1949 (Hour) 16 m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? Fell off docks into Creek

22. I hereby certify that I ~~attended the deceased from ..... 19.....~~ make Postmortem Examination ~~to~~ April 6 1949, ~~that I last saw the deceased alive on ..... 19.....~~, and that death occurred at 2 p. m., from the causes and on the date stated above.

SIGNATURE John M Kraffy M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis, Md. DATE SIGNED Apr. 6, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Buried
DATE Moreland Memorial
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) Balto Co (State)

DATE REC'D BY LOCAL REG. 4-7-49
REGISTRAR'S SIGNATURE L Wolfedrich
24. FUNERAL DIRECTOR James J Bruzdzenski ADDRESS 1407 Eastern Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03410

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold; MARYLAND; LENGTH OF STAY (in this place) 2 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Pauline (Middle) (Last) Dorrer

4. DATE OF DEATH: (Month) Apr. (Day) 13 (Year) 19 49

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 25 1868

9. AGE last birthday: 80 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY: Alien

13. FATHER'S NAME: John Tetekaskij

14. MOTHER'S MAIDEN NAME: Helen (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Eugene Dorrer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemorrhage	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio. vascular Disease	unknown
	(c) Diabetes Mellitus	11 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

260

61

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY Ooccur?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, 19..., to Apr. 13, 19 49, ~~that I last saw the deceased alive on~~, 19..., and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Gaffey M.D., Deputy Medical Examiner Annapolis. Maryland.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 4-18-49 NAME OF CEMETERY OR CREMATORY St. Stanislaus LOCATION (City, town, or county) (State) Baltimore Md

DATE REC'D BY LOCAL REG. 4/14/49 REGISTRAR'S SIGNATURE A.W. Hedrick MD

24. FUNERAL DIRECTOR ADDRESS George R. Weber 705 So. Ann st

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03411

CERTIFICATE OF DEATH

Reg. Dist. No. 20

M

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

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VS. A15

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterview. — LENGTH OF STAY (in this place): 15 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville - Md.
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Elizabeth	Dove	Apr	10	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White		May 4 1883	65 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Washington DC.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Anthony Malone	Sally Mattingly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		J. Owen Dove

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Myocarditis -	
Antecedent cause(s)	
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary insufficiency -	
(c) arteriosclerosis and diabetes mellitus	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Mar., 1948, to April 10, 1949, that I last saw the deceased alive on April 9, 1949 and that death occurred at 2:10 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Emily H. Wilson, M.D.	Lothian, Md.	4/14/49.

23. BURIAL, CREMATION ~~REMOVAL~~ (Specify)	DATE	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county) (State)
	4/13/49	Mt. Zion	Lothian A.A. Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/11/49	W.H. Clayton	E.A. Standerty & Son	

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APR 14 1949
BUREAU V. S.

Evidence for addition in #18 shown on: (c)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03412

FILM No. G 120 MAY 24 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital	STREET ADDRESS (If rural give location) 25 Larkins Street

3. NAME OF DECEASED (Type or Print)	(First) Cathrine	(Middle) Bugina	(Last) Dorsey	4. DATE OF DEATH	(Month) 4- (Day) 29- (Year) 1949
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-19-1917	9. AGE last birthday 31 yrs.	If under 1 year Months — Days — If under 24 hrs. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland A. A. Co. Md.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Roland Anderson	14. MOTHER'S MAIDEN NAME Carrie Fleetwood				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. 219-16-0269	17. INFORMANT Clinton Dorsey			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

199.1 55e

Immediate cause (a) heart failure, intestinal obstruction — 4-27-49

Antecedent cause(s) — 2 days

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Tumor of pelvic region,

(c) probably malignant or fast growing myoma [5/23/49 also]

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 4-25-49	19b. MAJOR FINDINGS OF OPERATION huge pelvic tumor involving bowels inoperable	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-13, 1949, to 4-28, 1949, that I last saw the deceased alive on 4-28, 1949, and that death occurred at 7:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edith Roeller M.D.		42 State Circle	Annapolis Md. 4-30-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5-1-1949	NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery	LOCATION (City, town, or county) (State) West Street Extended-Annapolis
DATE REC'D BY LOCAL REG. May 1, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mrs. Charles E. Hicks-	ADDRESS 43-45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03413

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Harman P.O. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural. LENGTH OF STAY (in this place) all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Harman P.O. COUNTY A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN —
STREET ADDRESS — (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Dennis (Last) Downs
4. DATE OF DEATH: (Month) April (Day) 24. (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 19, 1880
9. AGE last birthday: 68 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Asariah Downs
14. MOTHER'S MAIDEN NAME: Gaither
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If year, give war or dates of service) No
16. SOCIAL SECURITY NO.: No.
17. INFORMANT: Mrs. W. D. Downs - Harmans, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 93d

Immediate cause (a) Coronary Thrombosis — Interval between onset and death: Immediate

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio. Vascular Disease. — 2 years

(c) —

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: No
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 19 45, to April 24, 19 49, that I last saw the deceased alive on April 22, 19 49, and that death occurred at 6.30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) James S. Billingsley M.D. ADDRESS 108 Central Ave Glen Burnie Md. DATE SIGNED April 24 1949

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE April 27, 1949 | NAME OF CEMETERY OR CREMATORY Friendship Cem. | LOCATION (City, town, or county) A. A. Co., Md. (State)

DATE REC'D BY LOCAL REG. 4/26/49 | REGISTRAR'S SIGNATURE A.W. Hedrick | 24. FUNERAL DIRECTOR Wm. J. TICKNER & SONS | ADDRESS Balto., Md.

VS. A15

03414

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERN, (Rural) LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS THOMPSON AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERN, (Rural)
STREET ADDRESS (If rural give location) THOMPSON AVE.

3. NAME OF DECEASED (Type or Print) (First) PATRICIA (Middle) E (Last) EGGER

4. DATE OF DEATH (Month) April (Day) 17 (Year) 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH MARCH 24, 1946
9. AGE last birthday 3 - yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) SEVERN, MD. RURAL
12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME JOHN C. EGGER.
14. MOTHER'S MAIDEN NAME FRANCES C. WENTZEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NONE.
17. INFORMANT Mrs. John C. Egger, Thompson Ave. Severn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

272 Immediate cause (a) Lobar Pneumonia — 1 day

108 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hand-Schuller-Christian Disease — 2 yrs.

(c) Diabetes Insipidus

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED ~~While at~~ Work ☐ ~~Not While~~ At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to April 17th, 1949 that I last saw the deceased alive on April 16, 1949, and that death occurred at 2:00 A.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) Lipsky ADDRESS Mentor Md DATE SIGNED April 18th 1949

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL DATE THEREOF April 19, 1949 NAME OF CEMETERY OR CREMATORY GLEN HAVEN LOCATION (City, town, or county) GLEN BURNIE, (State) MD

DATE REC'D BY LOCAL REG. 4/18/49 REGISTRAR'S SIGNATURE L. J. D'Alba 24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

013415

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie; MARYLAND; LENGTH OF STAY (in this place) 3 mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 105 Chestnut Lane, N.W.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY Lancaster; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN White Stone; STREET ADDRESS (If rural give location) (Above) ✓

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Sommers (Last) Fisher

4. DATE OF DEATH: (Month) Apr. (Day) 6 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 6, 1880

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marine Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Maritime Commission

11. BIRTHPLACE (State or foreign country): Pleasantville, N. J.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John G. Fisher

14. MOTHER'S MAIDEN NAME: Anna Sommers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Mrs. Daisy K. Fisher

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CONGESTIVE HEART FAILURE	2 HRS
Antecedent cause(s) 420.0 93d	(b) ARTERIOSCLEROTIC HEART DISEASE	3 YEARS
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) NONE	—

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN) —; (COUNTY) —; (STATE) —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.; INJURY OCCURRED While at Work ☐ Not While At work ☐; HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 6, 1949, to Apr 6, 1949, that I last saw the deceased alive on Apr 6, 1949, and that death occurred at 4:10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Henry F. Zangara M.D. Glen Burnie Md 4/6/49

23. BURIAL, CREMATION / REMOVAL (Specify): Burial; DATE: April 9 1949; NAME OF CEMETERY OR CREMATORY: Woodlawn; LOCATION (City, town, or county) (State): Kilmarnock, Lancaster Co. Va.

DATE REC'D BY LOCAL REG. Apr 6, 1949; REGISTRAR'S SIGNATURE: L. J. DeAlba

24. FUNERAL DIRECTOR: Thomas W. Singleton; ADDRESS: Glen Burnie, Md

VS. A15

RECEIVED
APR 7 1949
BUREAU T. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03416

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 19 Hill St.	STREET ADDRESS (If rural give location) 19 Hill Street

3. NAME OF DECEASED (Type or Print) (First) Clarence Hubert Grant (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 17, 1949 19	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 24, 1887	9. AGE last birthday 62 yrs. If under 1 year Months 2 Days 23 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USN	10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (State or foreign country) S.C.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME A.Preston Grant			14. MOTHER'S MAIDEN NAME Mary Alice Grant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W. I and II	16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Emly Grant	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Thrombosis — 20 min.

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, generalized

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr, 1948, to Apr. 17, 1949, that I last saw the deceased alive on Apr 17, 1949, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

SIGNATURE G. M. Davis (Degree or title) M. D. ADDRESS Naval Hospital Annapolis DATE SIGNED 4/19/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 21, 49	Naval Cemetery	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 21, 1949	[signature]	B.L. Hopping and Son	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03417

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis, Md.
STREET ADDRESS (If rural give location): 214 West t.

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) F (Last) HAMBRUCH

4. DATE OF DEATH: (Month) 2-13-49 (Day) (Year) 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3-2-1888

9. AGE last birthday: 61 yrs. If under 1 year: Months 1 Days 11 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Frederick Hambruch

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mr Harry F. Hambruch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

330 **Immediate cause** (a) Sub-arachnoid Hemorrhage — 10 days

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive vascular disease — unknown

(c) Arterio-sclerosis. — unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 3, 1949, to Apr 13, 1949, that I last saw the deceased alive on Apr 13, 1949, and that death occurred at 10 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John M. Cathy M.D. — ADDRESS: Annapolis Maryland — DATE SIGNED: 4/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 4-16-49 | NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cemetery | LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: April 16, 1949 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: B.L. Hopping and Son | ADDRESS: Annapolis, Md.

RECEIVED
APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03418

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 14 Granfield St.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Henry	Harmon	April	12	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored	widow	June 1881	67 yrs.	10			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Laborer	Richmond Va.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Josephine Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Hypertensive Cardio Vascular Disease	5days
Antecedent cause(s) 443 932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	None	Yes ☐ No ☒ X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No	None			

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 8, 1949, to April 12, 1949 that I last saw the deceased alive on April 12, 1949, and that death occurred at 8.05 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Theodore H. Johnson	M.D.	46 Northwest Street Annapolis, Md.	4/13/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 16 1949	Brewer Hill	Annapolis,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 15, 1949	[signature]	J. B. Johnson	Annapolis.

RECEIVED
APR 19 1949
BUREAU V. S.

03419

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Linthicum Hgbts Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred: Md ave near Andover Rd

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Same County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Jane Harvell

3.(b) Social Security Number: none

4. Sex: Female

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Edgar Harvell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 25 1881

8. AGE: Years: 67 Months: 3 Days: 23 If less than one day ..... hrs. ..... min.

9. Birthplace: Dinwiddie Co. Va
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Retired

FATHER
12. Name: Silas Lewis
13. Birthplace: Virginia

MOTHER
14. Maiden name: Nancy ?
15. Birthplace: Virginia

16. Informant: Armeda Tales (daughter)
Address: R.F.D. Linthicum Hgbts Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 4-20-49 (month) (day) (year)

Cemetery or crematory: Zion Cem

Location: Petersburg Va

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley ave

19. 4/19 1949 LL
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 17 1949, at 5:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 9 1949, to Apr 17 1949 and that I last saw her alive on Apr 16 1949

		DURATION
Immediate cause of death	Gangrene of both legs	3 mo
Due to	Myocardial insufficiency	3 mo
Due to	Generalized arteriosclerosis	10 yrs
Other conditions	Senility	10 yrs

422.1
93d

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. B. Brumbaugh M. D. or other

Address: 5600 Main St. Elkridge Md Date signed: 4/17/49

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 Transcript

Evidence To change Surname & First name shown on:

03420

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 120 MAY -6 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Crownsville, A.A.C. State-Hospital MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 8/30/48
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State-Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Balt.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 524 Dolphin Street

3. NAME OF DECEASED (Type or Print) (Last) ~~(First)~~ HENRY (Middle) ~~(Last)~~ (First) WILLIAM

4. DATE OF DEATH (Month) 4 (Day) 30 (Year) 1949

5. SEX m
6. COLOR OR RACE col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 10/20/1892
9. AGE last birthday 56 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) taylor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY Md.

13. FATHER'S NAME James Henry
14. MOTHER'S MAIDEN NAME Sylvia Henry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Hospital-records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) left cerebral hemorrhage

83a Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) general arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks known to us since his admission 8/30/48.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/30/48, 19....., to 4/30/49, 19....., that I last saw the deceased alive on 4/30/49, 19....., and that death occurred at 11.50 P.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 7 May 5-49
NAME OF CEMETERY OR CREMATORY Md Auburn Cmty
LOCATION (City, town, or county) Westport City (State) Md

DATE REC'D BY LOCAL REG. 5/3/49
REGISTRAR'S SIGNATURE H.W. Hedrick DM
24. FUNERAL DIRECTOR George T. A. Gibson Sr. ADDRESS 1735 W.H. AVE Darwin Hill Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03421

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS ~~99 Calvert St.~~

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Elaine (Middle) Elaine (Last) Hill

4. DATE OF DEATH: (Month) 4 (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 4-8-1949

9. AGE last birthday yrs. If under 1 year: Months. Days 2 da. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Parole md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hill

14. MOTHER'S MAIDEN NAME: Gladys Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: John Hill

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia

763.0

Antecedent cause(s)

109

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: No

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-8-49, 19..., to 4-10-49, 19..., that I last saw the deceased alive on 4-10-49, 19..., and that death occurred at 12 A. M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Theodore N. Johnson M.D.

ADDRESS: 40 Northwest Street

DATE SIGNED: 4-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 4-12-49

NAME OF CEMETERY OR CREMATORY: Broad Neck

LOCATION (City, town, or county) (State): Skidmore, Md.

DATE REC'D BY LOCAL REG.: April 12, 1949

REGISTRAR'S SIGNATURE: Mrs. J. Brueck

24. FUNERAL DIRECTOR: William Reese

ADDRESS: 108 Washington Annapolis, Md.

RECEIVED
APR 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

034225

Reg. Dist. No. 14749

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 5720 Bellegrove Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5720 Bellegrove Road

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Pleasant Hines

3.(b) Social Security Number: 216-12-3052

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife: Beulah Lila Hines

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): November 11, 1885

8. AGE: Years	Months	Days	If less than one day
63	7	7	....hrs. ....min.

9. Birthplace: Brooklyn Md. (Town, county, and state)

10. Usual occupation: — Janitor

11. Industry or business: —

FATHER — 12. Name: Charles Henry Hines Sr.

FATHER — 13. Birthplace: Cedar Hill Md.

MOTHER — 14. Maiden name: Matilda Snowden

MOTHER — 15. Birthplace: Glen Bernie

16. Informant: Esther C. Taylor

Address: 5721 Bellegrove Road.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof April 7 1949 (month) (day) (year)

Cemetery or crematory: Mt. Calvery Cem.

Location: Brooklyn A.A.Co.Md.

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantly Ave.

19. 4-6 49 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 4 1949 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26 1949 to April 3 1949, and that I last saw him alive on April 3 1949.

Immediate cause of death	DURATION
Cancer of small intestine	?
Due to	
Due to	
Other conditions	

152

462

(Include pregnancy within 3 months of death)

Major findings of operations: .....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R B Lightsey M. D. or other

Address: 501 Cherry Hill Road Date signed: 4-4-49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03423

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural; LENGTH OF STAY (In this place) 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1315 Edmondson Avenue

3. NAME OF DECEASED (Type or Print): (First) Howard (Middle) (Last) Johnson
4. DATE OF DEATH: (Month) April (Day) 10, (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: October 5, 1876
9. AGE last birthday: 72 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Moses Johnson
14. MOTHER'S MAIDEN NAME: Amy Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If year, give war or dates of service)
16. SOCIAL SECURITY NO. [illegible]
17. INFORMANT: Crownsville State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

334 Immediate cause (a) myodegeneratio cordis

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) psychosis with cerebral arteriosclerosis — 10 months.

(c) none

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 25th, 1948, to April 10th, 1949, that I last saw the deceased alive on April 10, 1949, and that death occurred at 12,25 P.M., from the causes and on the date stated above.

SIGNATURE Jacob Marquester M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation | DATE April 13, 1949 | NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | LOCATION (City, town, or county) A-A-County | (State) Md

DATE REC'D BY LOCAL REG. 4/13/49 | REGISTRAR'S SIGNATURE D.W. Hedrick | 24. FUNERAL DIRECTOR Charles G. Cooper | ADDRESS 510 North Carlton Avenue Baltimore.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03424

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 1 mo. 23 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS 25 La Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 25 La Fayette

3. NAME OF DECEASED (Type or Print): (First) Leo (Middle) Lurare (Last) Johnson

4. DATE OF DEATH: (Month) Apr. (Day) 2 (Year) 1949

5. SEX: male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Feby. 7. 1949

9. AGE last birthday: — yrs. If under 1 year: Months. 1 Days 26 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U-S-A.

13. FATHER'S NAME: Stephen Johnson

14. MOTHER'S MAIDEN NAME: Roberta Reed.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Stephen Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho- Pneumonia — Interval between onset and death: 4 days

500

Antecedent cause(s)

107

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Bronchitis — 8 days

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from....., 19....., to~~ Apr. 2, 19 49, ~~that I last saw the deceased alive on....., 19.....~~, and that death occurred at 6:45 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M Claffy M. D., Deputy Medical Examiner Annapolis Md. Apr. 2. 1949

23. BURIAL, CREMATION, REMOVAL (Specify) DATE April 4 1949 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. April 4, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR William Reese Jr. ADDRESS 108 Washington St. Annapolis, Md.

RECEIVED
APR 5 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03425

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 71 Ritter St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS 71 Ritter St (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Johnson
4. DATE OF DEATH: (Month) 4 (Day) 17 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 23, 1873
9. AGE last birthday: 75 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): West River, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Anna Brown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Phillip Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Cardiac Failure	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-renal-vascular disease	unknown
	(c) General arterio-sclerosis	unknown

442
131a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Post mortem Examination 19..., to April 17, 1949, ~~that I last saw the deceased alive on ..., 19...~~, and that death occurred at 3:52 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Allen M. Claffy M.D. Deputy Medical Examiner Annapolis Md 4/21/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 4-21-49 | NAME OF CEMETERY OR CREMATORY: Brewer Hill | LOCATION (City, town, or county) (State): Annapolis A.A. Md.

DATE REC'D BY LOCAL REG.: April 21, 1949 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR ADDRESS: William Reese, II

RECEIVED
APR 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03426

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Woodland Beach
STREET ADDRESS (If rural give location): Edgewater Post Office

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	C.	Jones	4 -	13-	49 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	2-18-1861	88 yrs.	1	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknonw	unknown	Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Unknown	Unknown	Hospital Record Office

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) arteriosclerotic cardiovascular renal disease — 10 yrs (?)

442

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

131a

(b) Gen. arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerotic gangrene Rt. foot

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 4/9, 1949, to 4/13, 1949, that I last saw the deceased alive on 4/13, 1949, and that death occurred at 9:20 a m., from the causes and on the date stated above.

SIGNATURE: S Bowers MD (Degree or title) — ADDRESS — DATE SIGNED: 4/13/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-14-49	Edward's Chapel Cemetery	Riva Rd. Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 14, 1949	[signature]	Ben L. Hopping and Son	Annapolis, Maryla

VS. A15

RECEIVED
APR 16 1949
BUREAU V. S.

03427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred: Cedar crest nursing home
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: .....
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1811 - S. Charles St.
(If rural, give LOCATION)
2.(a) If veteran, name war: .....

3.(a) FULL NAME: Milton Glenn Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Catherine Ford.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 16 - 1874

8. AGE: Years	Months	Days	If less than one day
74	4	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Oysterman. -
11. Industry or business

FATHER 12. Name	Wm. Jones
FATHER 13. Birthplace	Kent Island, Md.
MOTHER 14. Maiden name	Louisa Cummings.
MOTHER 15. Birthplace	Eastern Shore, Md.

16. Informant: Mrs. Hazel Wood (Niece)
Address: 404 - Normandy ave - Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/4/49 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto. Md.

18. Funeral director: Wm Cook Inc.
Address: 1217 St. Paul st. Balto. Md.

19. April 2nd 1949 (Date rec'd by registrar) R.W. McMedinah Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 1 1949 at 10 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to 3/31/49 19..... and that I last saw h... alive on 3/31/49 19.....

	DURATION
Immediate cause of death: Mitral Insufficiency	3½ mos
Due to: Chronic interstitial nephritis	3½ mos
Due to: Cirrhosis of the liver	3½ mos
Other conditions	

581.0
124.6 (Include pregnancy within 3 months of death)

Major findings of operation: .....
Date of op. .....
Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Irvin Lee Bunker MD. M. D. or other
Address: Glen Burnie Md. Date signed: 4/6/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03428

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Hanover (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs

Hospital, institution, or street address where death occurred: Ridge Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: S County:

City or town: Same (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Robert William Jones

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Ruth Tamble Jones

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Dec 18/1880

8. AGE: Years 68 | Months 4 | Days 3 | If less than one day ... hrs. ... min.

9. Birthplace: Anne Arundel Co. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Various

FATHER
12. Name: Silas Jones
13. Birthplace: Howard Co md

MOTHER
14. Maiden name: Cordelia Allen
15. Birthplace: Charles Co md

16. Informant: Ruth Jones wife

Address: Box 124 Hanover md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4-25-49 (month) (day) (year)

Cemetery or crematory: Staints Rest

Location: Harmons Md.

18. Funeral director: Mrs. Katie R. Williams

Address: 322 N. Schroeder St.

19. 25 April 1949 (Date rec'd by registrar) Cecil Moorhead Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr 21 1949, at 2:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 20 1949 to Apr 21 1949 and that I last saw him alive on Apr 21 1949

Immediate cause of death: Bronchi Pneumonia — DURATION: 3 da

Due to: Myocardial Insufficiency — 1 yr

Due to: 422.2

Other conditions: 92 b

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Dr. B. B. Brumbaugh M. D. or other

Address: Elpridge Md. Date signed 4/22/49

RECEIVED
APR 26 1949
BUREAU V. S.

Evidence to re-arrange #18 shown on:

FILM No. G 1[illegible] MAY 24 1949

03429

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 109 Lafayette Ave

3. NAME OF DECEASED (Type or Print) (First) Leslie (Middle) Seth (Last) Klakring

4. DATE OF DEATH (Month) 4 (Day) 12 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 11-7-1884
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Emp. Naval Academy
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Olaf Klakring
14. MOTHER'S MAIDEN NAME Louise James

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. —
17. INFORMANT Thomas B. Klakring

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocarditis & Myocardial Insufficiency	3 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Unresolved Pneumonia Lop Lung	2 months
	(c) Pericarditis with Effusion	2 months

422.2
93e

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Rheumatoid Arthritis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-10, 1949, to 4-12, 1949 that I last saw the deceased alive on 4-12, 1949, and that death occurred at 12 20 p.m., from the causes and on the date stated above.

SIGNATURE George C. Basil M.D. (Degree or title) ADDRESS Annapolis Md DATE SIGNED 4-13-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 4-14-49
NAME OF CEMETERY OR CREMATORY U.S. Naval Academy
LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. April 14, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 16 1949
BUREAU V. S.

03430

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH COUNTY: A A MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Edgewater COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater — LENGTH OF STAY (in this place): 12 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Paris (Middle) George (Last) Lambert			4. DATE OF DEATH (Month) Apr (Day) 23 (Year) 1949		
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: Jan 15, 1864	9. AGE last birthday: 85 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timber	10b. KIND OF BUSINESS OR INDUSTRY: Sawmill	11. BIRTHPLACE (State or foreign country): Bland Co. Va.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: Samuel Lambert		14. MOTHER'S MAIDEN NAME: Elizabeth Lambert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Edgar Lambert			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

177 51b

Immediate cause (a) Gen carcinomatosis — 8 mos

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ca of prostate

(c) Bronchiectasis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1948	19b. MAJOR FINDINGS OF OPERATION: Ca of prostate	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1942, to Apr 23, 1949, that I last saw the deceased alive on Apr 22, 1949, and that death occurred at 9.10 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) S. Bonsuch M.D. ADDRESS Annapolis Md. DATE SIGNED 4/24/49

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~	DATE: April 25-49	NAME OF CEMETERY ~~OR CREMATORY~~: Mt. Zion Cem.	LOCATION (City, town, or county) (State): Lothian Md
DATE REC'D BY LOCAL REG.: April 24, 1949	REGISTRAR'S SIGNATURE: Edward Collinson	24. FUNERAL DIRECTOR: T. A. Hardesty + Son	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Lou Emma Lambert

Edgar Lambert - Edgewater
Jesse " Fullerton, Md
Ola ~~Ley~~ Ledane Edgewater
Carson Lambert "
Price " Bland. Va

Brother
James E. Lambert
Bland, Va.

Annapolis.

RECEIVED
APR 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03431

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 40 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 34 Pleasant Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 34 Pleasant Street

3. NAME OF DECEASED (Type or Print): (First) Emma (Middle) (Last) Lee
4. DATE OF DEATH: (Month) 4 (Day) 30 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 3-17-1880
9. AGE last birthday: 69 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laudress
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Simon
14. MOTHER'S MAIDEN NAME: Mary Ellen Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Charlott E. Cornish

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Rectal Carcinoma

154 Antecedent cause(s)

462 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-26 1945, to 4-30 1949, that I last saw the deceased alive on 4-30 1949, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE O. T. Allen | (Degree or title) M D | ADDRESS 10 Carroll | DATE SIGNED 5-2-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 5-3-1949 | NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery | LOCATION (City, town, or county) (State) West St. Extended Annapolis, Md.

DATE REC'D BY LOCAL REG. May 3, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR Mrs. Charles E. Hicks | ADDRESS 43-45 Northwest St.

RECEIVED
MAY 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03432

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Shadyside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-2 years

Hospital, Institution, or street address where death occurred: Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Shadyside

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lotta Lee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Robert H. Lee

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1871

8. AGE: Years 77 Months 6 Days 3 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: William Phelps

13. Birthplace: Churchton, Md.

MOTHER

14. Maiden name: Laura Levy

15. Birthplace: Baltimore

16. Informant: Ralph Lee

Address: Shadyside, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 18 1949 (month) (day) (year)

Cemetery or crematory: Quaker Cem

Location: Galesville Md

18. Funeral director: D. A. Hardesty & Son

Address: Galesville Md

19. April 17 1949 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Apr. 16 1949, at 10:5 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary Occlusion — DURATION

Due to:

Due to:

Other conditions: 420.1 9Ho

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D. Attending M.D. or Coroner

Address: Annapolis, Md. Date signed: 4/16/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

RECEIVED
APR 23 1949
BUREAU M. E.

03433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 days.

Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home

How long in hospital or institution? 31 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore 2

(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 - South Poppleton St

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Franklin Lowe.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed.

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug. 28 - 1873

8. AGE: Years: 75 Months: 7 Days: 27 If less than one day: ..... hrs. ..... min.

9. Birthplace: Ellicott City, Md. (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER
12. Name: George Lowe
13. Birthplace: Ellicott City, Md.

MOTHER
14. Maiden name: Frances Sinnamon
15. Birthplace: Ellicott City, Md.

16. Informant: Cedar Crest Nursing Home

Address: Severna Park, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/27/49 (month) (day) (year)

Cemetery or crematory: Schmortz

Location: Baltimore Md

18. Funeral director: William Cook Inc

Address: 1217 N Paul St

19. 4/27 1949 (Date rec'd by registrar) A.W. Hedrick Jr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 25th 1949, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1949, to April 25 1949 and that I last saw him alive on 4/23/49 19

Immediate cause of death	DURATION
Mitral Insufficiency	31 days
Due to: Chronic Interstitial nephritis	31 days
Due to: Hypertension	31 days
Other conditions: 444 131a (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Gustave H Fischer MD. M. D. or other

Address: Glen Burnie, Md Date signed: 4/25/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45 5M

Evidence for additional info. in item #23 is on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03434

FHM No. G 120 MAY 18 1949

CERTIFICATE OF DEATH

BC Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. COUNTY: ------
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups · LENGTH OF STAY (in this place): 40 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Md. House Correction	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Richard		Marcus	April	7,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored	Divorced	2/8/04	45 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Labor	Laborer	Macon, Ga.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Emma Marcus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
UNKNOWN	-------	Maryland House Correction

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Edema of Lungs

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cardio-vascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 28, 1949, to Apr. 7, 1949, that I last saw the deceased alive on Apr. 7, 1949, and that death occurred at 6:15 P.m., from the causes and on the date stated above.

SIGNATURE: John A Clark (Degree or title) ADDRESS: John A. Clark M.D., Physician in Charge. - MHC Jessups, Md. DATE SIGNED: Apr. 8, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 26, 1949	Cherry Hill Cemetery	Jessups, An. Ar. Co., Md.

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Apr 25-49	Clara Haslup	W L Collins	Jessup Md

VS. A15

RECEIVED
MAY 13 1949
BUREAU V. S.

03435

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 B King Geo. St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS MD
STREET ADDRESS (If rural give location) 212 B KING GEORGE

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) T. (Last) MASON

4. DATE OF DEATH (Month) 4 (Day) 9 (Year) 1949

5. SEX F | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH 1869 UNKNOWN | 9. AGE last birthday About 80 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) DENVER COL. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME EZRA TOTTLE | 14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT CHAN C. MASON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

196 **Immediate cause** (a) Circulatory failure — 2 days

55b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malignancy, bone, type and source undetermined. (X ray evidence only). — Approx. 6 mos

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Patient was a Christian Scientist making treatment and investigation exceedingly difficult. X rays were obtained of ribs & vertebrae a few days before death.

19a. DATE OF OPERATION none | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 April, 1949, to 9 Ap, 1949, that I last saw the deceased alive on 8 Ap, 1949, and that death occurred at 12.40 A.m., from the causes and on the date stated above.

SIGNATURE Donald H. Hooker, M.D. (Degree or title) | ADDRESS 53 Cornhill St. Annapolis, Md | DATE SIGNED 9/Ap 49.

23. ~~BURIAL~~, CREMATION ~~REMOVAL (Specify)~~ | DATE THEREOF 4-9-49 | NAME OF CEMETERY OR CREMATORY Ft. LINCOLN | LOCATION (City, town, or county) PRI. GEO. CO (State) MD

DATE REC'D BY LOCAL REG. April 9, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR JOHN M. TAYLOR & SON | ADDRESS ANNAPOLIS MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03436

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 119 Archwood Avenue

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Shore (Last) MC CLOY

4. DATE OF DEATH: (Month) 4 (Day) 10 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1-2-1888

9. AGE last birthday: 61 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: W. S. McCloy

14. MOTHER'S MAIDEN NAME: Adda Manees

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): I and II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CEREBRAL THROMBOSIS	10 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) PULMONARY EMPHYSEMA	Years
	(c) BRONCHIAL ASTHMA	Years

241
8336

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - - - - - - - - -

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - -

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: - - - - (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? - - - - - - - - - -

22. I hereby certify that I attended the deceased from April 5, 1949, to April 10 1949, that I last saw the deceased alive on April 10, 1949, and that death occurred at 10 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title): N. M. Greene — ADDRESS: N.M. GREENE, LTJG., MC, USNR, U.S. Naval Hospital, Annapolis, Maryland — DATE SIGNED: 4-11-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) — DATE: 4/13/49 — NAME OF CEMETERY OR CREMATORY: U.S. Naval Academy — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: April 12, 1949 — REGISTRAR'S SIGNATURE: J. T. O'Connell

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor & Son - Annapolis, Md.

VS. A15

RECEIVED
APR 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03437

Reg. Dist. No. 242 or

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45 5M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Fairhaven

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? —

Hospital, institution, or street address where death occurred:

Rte 423

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1709 Trinidad Ave. N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Elmer Louis Mercurio

3.(b) Social Security Number: 579-12-9637

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 26 - 1922

8. AGE: Years	Months	Days	If less than one day
26	8		hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Construction, time keeper

11. Industry or business: Construction

FATHER — 12. Name: Ralph Mercurio

13. Birthplace:

MOTHER — 14. Maiden name: Helewa Secila Louis

15. Birthplace:

16. Informant:

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/29/49 (month) (day) (year)

Cemetery or crematory: Arlington Nat. Cem.

Location: Arlington, Va.

18. Funeral director: Wastler Funeral Home

Address: 321 East Cap St. SE #320

X 28 Apl 49 Chas E. Evans

19 (Date received by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 19 49 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased~~ from

19 to 19

and ~~that I last saw him~~ alive on 19

Immediate cause of death	DURATION
Buried to death	
Due to: Plane crash	
Due to:	
Other conditions: 866.5	
173 (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 4/26/49

Where did injury occur? Fairhaven (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Highway 423

Means of injury: Plane crash Injured at work? Yes

23. SIGNATURE: E. Fulton Ritchings, M.D.

M. D. or Coroner

Address: Annapolis, Md. Acting DME Date signed: 4/27/49

RECEIVED
MAY 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03438

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Eastern Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 17 Eastern Ave.

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) (Last) MEZICK

4. DATE OF DEATH: (Month) Apr (Day) 16 (Year) 19 49

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, ~~MARRIED~~, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: Feb. 2, 1869

9. AGE last birthday: 80 yrs. — If under 1 year: Months. 2 Days 14 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Episcopal Minister

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Baptist Mezick

14. MOTHER'S MAIDEN NAME: Anna Rebecka Reidout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Frank Corner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443 **Immediate cause** (a) Acute Cardiac failure — Sudden

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardio-vascular disease — 2 years

(c) Arterial hypertension — unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 1, 1949, to Apr. 16, 1949, that I last saw the deceased alive on Apr. 14, 1949 and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE John M. Claffy — (Degree or title) M.D. — ADDRESS Annapolis, Md. — DATE SIGNED 4/18/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE Apr. 19-1949 | NAME OF CEMETERY OR CREMATORY Green Mount Cem. | LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. April 19, 1949 | REGISTRAR'S SIGNATURE Mrs. Branch | 24. FUNERAL DIRECTOR John M. Taylor Son — ADDRESS Annapolis Md.

VS. A15

RECEIVED
APR 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03439

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TRUXTON HGHTS
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MD — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: TRUXTON HEIGHTS
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) ERNEST (Middle) R. (Last) MINTER

4. DATE OF DEATH: (Month) 4 (Day) 7 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)

8. DATE OF BIRTH: 1-2-1885

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): ATLANTA GA

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: KATHERINE J. MINTER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of the Larynx — Interval Between Onset and Death: 6 months Duration.

161 470

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None — 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/1, 1948, to 4/7, 1949, that I last saw the deceased alive on 4/7, 1949, and that death occurred at 3 P.M., from the causes and on the date stated above.

SIGNATURE: Albert L. Anderson M.D. (Degree or title) ADDRESS: Annapolis Md DATE SIGNED: 4/7/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE: 4-9-49 | NAME OF CEMETERY OR CREMATORY: CEDAR GROVE | LOCATION (City, town, or county): ANNAPOLIS | (State): MD

DATE REC'D BY LOCAL REG.: April 9, 1949 | REGISTRAR'S SIGNATURE: J. T. Branch

24. FUNERAL DIRECTOR: JOHN M. TAYLOR | ADDRESS: ANNAPOLIS MD

VS. A15

RECEIVED
APR 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03440 Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville; STATE MARYLAND; LENGTH OF STAY (In this place) 1/13/45; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Balt.; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore; STREET ADDRESS (If rural, give location) 818 N. Dallas Street

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) MURRAY (Last) PALMER

4. DATE OF DEATH: (Month) 4 (Day) 3 (Year) 1949

5. SEX M

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W

8. DATE OF BIRTH (?) ABT. 1889

9. AGE Last birthday 60 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during greater part of working life, even if retired) laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) B altimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles E. Palmer

14. MOTHER'S MAIDEN NAME Katie Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT H ospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General arteriosclerosis — Interval between onset and death: known to us since 1/13/45

450.0

Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c) senile Psychosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/13/45, 19..., to 4/3/49, 19..., that I last saw the deceased alive on 4/2/49, 19..., and that death occurred at 0530 A m., from the causes and on the date stated above.

SIGNATURE Carl Augenstein M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE April 8-1949 | NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. | LOCATION (City, town, or county) (State) Brooklyn P.O. Co. Md

DATE REC'D BY LOCAL REG. 4-6-49 | REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Percy O. Wilson | ADDRESS 1000 Granby

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1549
1660
1885

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03441

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (Fairfax) RFD
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency hospital	STREET ADDRESS (If rural give location) Annapolis, Md.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Jesse James Pennington

4. DATE OF DEATH (Month) (Day) (Year): April 16, 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Married	March 1, 1882	67 yrs.	1	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		West Virginia	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Washington Pennington	Virginia Selby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	no	235-03-8117	Mrs Annie L. Pennington

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260

Immediate cause (a) Diabetes Melitus c̄ Acidosis & Coma — 7 days

61

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Said to have had pernicious anaemia — 4-5 yrs

(c) treated with liver injections.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Had frontal brain injury 40 yrs. ago.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10, 1949, to 4/16, 1949, that I last saw the deceased alive on 4/15, 1949, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Maurice F. Klawans, MD Annapolis, Md

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 18, 49	Glen Haven Memorial	Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 18, 1949	[signature]	Ben L. Hopping and Son	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03442

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
LENGTH OF STAY (in this place) 18 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Telegraph Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
STREET ADDRESS (If rural, give location) Telegraph Road

3. NAME OF DECEASED (Type or Print) (First) Herbert (Middle) (Van) (Last) Querry
4. DATE OF DEATH (Month) April (Day) 26 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Apr. 29 1931
9. AGE last birthday 18 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none due to being crippled
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carl Van Querry
14. MOTHER'S MAIDEN NAME Ida Grumm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT Ida Van Querry

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
822.5	Immediate cause	(a) Lobar Pneumonia	4 days
170C	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Shock from automobile accident	9 days.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Highway
(CITY OR TOWN) nr. Upper Marlboro, (COUNTY) Pr. Geo. (STATE) Md.
TIME OF INJURY (Month) Apr. (Day) 17 (Year) 1949 (Hour) 11 m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Auto in which he was riding overturned

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy, M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis, Md DATE SIGNED 5/17/49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 4/29/49
NAME OF CEMETERY OR CREMATORY Glen Haven Cem.
LOCATION (City, town, or county) Anne Arundel Co. Md. (State)

DATE REC'D BY LOCAL REG. 4/28/49
REGISTRAR'S SIGNATURE A. W. Hedrich dm
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons ADDRESS Balto. Md.

Querry
last

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Substitute cert. rec'd from Dr. Claffy on 6/22/49 - orig. cert. filed in "2 for 1" file in V.S. Letter in file

JUN 21 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03443 27

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft Meade
LENGTH OF STAY (in this place): 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Kentucky — COUNTY: Casey
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Liberty
STREET ADDRESS (If rural give location): Route #5

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAN	ALVIN	RICHARDSON	April	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Single	1900	48 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Soldier	US Army	Kentucky	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Yes	* *	US Army (Service Record)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
581.0 Immediate cause	(a) Bleeding esophageal varices	2½ hrs
124 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cirrhosis of liver.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None	- -	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
- -	-	- -	- -	- -

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
-	-	-	m.		- -

22. I hereby certify that I attended the deceased from 3 April, 1949, to 3 April, 1949, that I last saw the deceased alive on 3 April, 1949, and that death occurred at 0352 hrs. m., from the causes and on the date stated above.

SIGNATURE (Doctor or title)	ADDRESS	DATE SIGNED
Melville C. Magida M. G. MAGIDA Capt., MC	Station Hospital Ft Meade Md	6 April 49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Removal	3 April 49	Unknown	Liberty	Ky

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6 April 49	E. K. BURNSIDE, CAPT, MSC	Lily & Zieler Inc	Balto, Md.

RECEIVED
APR 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03444

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: A.A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis Md.
STREET ADDRESS (If rural give location): 39 Murray Ave

3. NAME OF DECEASED (Type or Print) (First) Carrie (Middle) A. (Last) Russell

4. DATE OF DEATH (Month) Apr (Day) 28th (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: Dec 3-1874
9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Practical nurse
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): A. A. Co Md.
12. CITIZEN OF WHAT COUNTRY: N.S.A.

13. FATHER'S NAME: John Norfolk
14. MOTHER'S MAIDEN NAME: Elizabeth Carr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Fenwick Lyons

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis & Myocardial Insuffering — 4 years

422.1 93d

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arterio Sclerosis — several years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to April 28, 1949, that I last saw the deceased alive on April 27, 1949, and that death occurred at 4 a m., from the causes and on the date stated above.

SIGNATURE: George C Basil (Degree or title) M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 4-28-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) — DATE THEREOF: 4-30-49 — NAME OF CEMETERY OR CREMATORY: St. Anne's — LOCATION (City, town, or county): Annapolis (State) Md.

DATE REC'D BY LOCAL REG.: April 28, 1949 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: John M. Taylor Son — ADDRESS: Annapolis Md

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1949
BUREAU V. S.

Dr. Allen

03445

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Spa Road 829
STREET ADDRESS (If rural give location): Annapolis

3. NAME OF DECEASED (Type or Print) (First) James (Middle) Walter (Last) Savoy
4. DATE OF DEATH (Month) April (Day) 28 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: June 25, 1938
9. AGE last birthday: 10 yrs. — If under 1 year: Months 10, Days 13 — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jones' Station Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Savoy
14. MOTHER'S MAIDEN NAME: Alice Woods
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Alice Savoy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intracranial Hemorrhage

904.0 Antecedent cause(s)

1860 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fall

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
(CITY OR TOWN): Annapolis (COUNTY): aa (STATE): Md
TIME OF INJURY (Month) 4 (Day) 2, (Year) 49 (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Fall

22. I hereby certify that I attended the deceased from April 2, 1949, to April 28, 1949, that I last saw the deceased alive on April 28, 1949, and that death occurred at 11:25 a.m., from the causes and on the date stated above.

SIGNATURE: T. T. Allen (Degree or title): M.D. ADDRESS: 10 Carroll DATE SIGNED: 4-30-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: May 1, 1949 — NAME OF CEMETERY OR CREMATORY: Carpenters Hill — LOCATION (City, town, or county): Jones' Md. (State):
DATE REC'D BY LOCAL REG.: May 1, 1949 — REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: J.B. Johnson, Annapolis, Md. ADDRESS:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MAY 4 1949
BUREAU F. S.

03446

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

#4- Evidence shown on

FILM NO. G 120 APR 18 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lake Shore, Pasadena | MARYLAND | LENGTH OF STAY (in this place): Md. 9 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland | COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lake Shore, Pasadena, Md. P.O.
STREET ADDRESS (If rural give location): Mountain Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CHARLES		SCHULZE	April	9	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Married	May 18, 1896	62 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guard (Retired 1943)	Tuller Con. Co.	Baltimore, Md.	US

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles Schulze	Catherine Klinglehofer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no	214 10 0006	Mrs. Beulah Schulze

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
332 Immediate cause	(a) Lobar Pneumonia	5 days
108 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hemiplegia	5 years
	(c) Cerebral Thrombosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerotic Dementia	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan 15, 1944 to April 9, 1949, that I last saw the deceased alive on April 5, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: [illegible] (Degree or title) ADDRESS: Odenton Md DATE SIGNED: 4-9-49.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 11, 49	Glen Haven	Glen Burnie	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
4/10/49	[illegible]	Thomas W. Duffton	Glen Burnie

VS-A15

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APR 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03447 22

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45 M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harmans
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 month
Hospital, institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lovell
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Warner Oliver Sewell, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored.	Single.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January-28-1949

8. AGE: Years | Months: 2 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Harmans, Md.
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER
12. Name: Warner Oliver Sewell,
13. Birthplace: Harmans, Md.

MOTHER
14. Maiden name: Frances Simms,
15. Birthplace: Dorsey, Md.

16. Informant: Frances Sewell (Mother)
Address: Harmans, Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof: April 19 49 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Harmans Md.
18. Funeral director: The H C White Co Inc
Address: Laurel Md.

19. April 19 49 (Date rec'd by registrar) Clara Kasluf Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 18 1949 at 5-45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19— to — 19—
and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
Suffocation	sudden.
Due to	
Due to	
Other conditions	

924.0
182
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: (Accident) Date of 4/18/49
Where did injury occur? Harmans, A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home.
Means of injury: Slept with parents Injured at work? No

23. SIGNATURE: Gustave A. Gardner M.D.
(Attending physician, Dep. Coroner, medical examiner, C.M.O., or other)
Address: Glen Burnie, Md. Date signed: 4/18/49

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MAY 13 1949
BUREAU V. S.

M

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 03448

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 220 Asquith Street

3. NAME OF DECEASED (Type or Print) (First) William (Middle) (Last) Sherard
4. DATE OF DEATH (Month) 4/21/49 (Day) (Year) 19

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 6/5/1890
9. AGE last birthday 58 yrs. If under 1 year Months Days ****** If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) not known (Maryland)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Swinton Sherard
14. MOTHER'S MAIDEN NAME Laura Sals

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) **********
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
026 Immediate cause	(a) Central Nervous System Lues	known since 4/13/49
30C Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **********
19b. MAJOR FINDINGS OF OPERATION **********
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) **********
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ******* m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ **
HOW DID INJURY OCCUR? **

22. I hereby certify that I attended the deceased from 4/13/49, 19....., to 4/21/49, 19....., that I last saw the deceased alive on 4/21/49, 19....., and that death occurred at 11:00 A.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 4/21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE April 28/49 NAME OF CEMETERY OR CREMATORY Red Hill Cemetery LOCATION (City, town or county) Goldsboro N.C. (State)

DATE REC'D BY LOCAL REGISTRAR 4/25/49 REGISTRAR'S SIGNATURE H. W. Hedrick Dm
24. FUNERAL DIRECTOR Elroy O Wilson ADDRESS 1000 Brantley Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03449

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earleigh Heights | LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Berle B

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore

STREET ADDRESS (If rural give location) 1021 W. Sex. St Balto. Md

3. NAME OF DECEASED (Type or Print) (First) Berle (Middle) B. (Last) Siler

4. DATE OF DEATH (Month) Apr. (Day) 16 (Year) 1949

5. SEX Male | 6. COLOR OR RACE negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH 3/3/22 | 9. AGE last birthday 27 yrs. | If under 1 year Months Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ralph Siler | 14. MOTHER'S MAIDEN NAME Mary Siler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. 212-30-1471 | 17. INFORMANT Ralph Siler 919 W. Fayette St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

981.0 Immediate cause (a) Gun-shot wound in head — sudden

Antecedent cause(s)

166 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Homicide

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Homicide | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) lawn of father's home | (CITY OR TOWN) Earleigh Heights (COUNTY) A. A. (STATE) Md.

TIME OF INJURY (Month) Apr. (Day) 16, (Year) 1949 (Hour) about 3 A m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? shot with .22 cal single barrel shot-gun.

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination, ~~19~~, ~~to~~ Apr. 16, 1949, ~~that I last saw the deceased alive on~~, ~~19~~, and that death occurred at about 3 A m., from the causes and on the date stated above.

SIGNATURE John M. Claffy M.D., Deputy Medical Examiner (Degree or title) | ADDRESS Annapolis, Maryland | DATE SIGNED Apr. 16, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 4-20-49 | NAME OF CEMETERY OR CREMATORY Mt Arbeuse Cem. | LOCATION (City, town, or county) Balto. Md (State)

DATE REC'D BY LOCAL REG. 4-19-49 | REGISTRAR'S SIGNATURE LL | 24. FUNERAL DIRECTOR Elroy O. Wilson | ADDRESS 1000 Brantly ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Transcript

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03450

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (In this place): 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Balt. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, City
STREET ADDRESS (If rural, give location): not known

3. NAME OF DECEASED (Type or Print): (First) James (Middle) (Last) Simmons
4. DATE OF DEATH: (Month) 4/21/49 (Day) (Year) 19

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: not known about 1883
9. AGE last birthday: 66(7) yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: non e
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: Rachael Simmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	known since 3/7/49
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	known since 10 years
	(c) Imbecility	known since admission

334

93d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) in. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/29/19, 19....., to 4/21/49, 19....., that I last saw the deceased alive on 4/21/49, 19....., and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) — ADDRESS: Crownsville, Maryland — DATE SIGNED: 4/21/49

23. BURIAL, CREMATION REMOVAL (Specify) — DATE: 4/25/49 — NAME OF CEMETERY OR CREMATORY: Hospital — LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 4/25/49 — REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg. — 24. FUNERAL DIRECTOR: ~~James A Hayes 14~~ Hospital — ADDRESS: Supt of

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APR 27 1949
BUREAU V. S.

03451

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Sudley, A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sudley
LENGTH OF STAY (in this place) 15 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Sudley, Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sudley
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Stanley (Middle) K. (Last) Simmons
4. DATE OF DEATH: (Month) Apr. (Day) 21. (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: ABT. 1894
9. AGE last birthday: 55 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Implements
10b. KIND OF BUSINESS OR INDUSTRY: Salesman
11. BIRTHPLACE (State or foreign country): Sudley
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Simmons
14. MOTHER'S MAIDEN NAME: Ida Brandell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If year, give war or dates of service): 1st World War.
16. SOCIAL SECURITY NO.
17. INFORMANT: Aubrey Simmons

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Coronary Thrombosis

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 21, 1949, to April 21, 1949, that I last saw the deceased alive on Apr. 21, 1949, and that death occurred at 7.30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Emily H Wilson M.D. Lothian, Md. 4/21/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE Apr. 23, 1949 NAME OF CEMETERY OR CREMATORY: Quaker Cem LOCATION (City, town, or county) (State): Galesville Md.

DATE REC'D BY LOCAL REG. April 21, 1949
REGISTRAR'S SIGNATURE: D. B. Dent.
24. FUNERAL DIRECTOR ADDRESS: D.A. Stanley + Son

RECEIVED
APR 23 1943
BUREAU Y. N

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03452

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville, LENGTH OF STAY (in this place) 26 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Galesville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Jessie (Middle) Dubel (Last) Smith

4. DATE OF DEATH (Month) April (Day) 2 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH March 13, 1898
9. AGE last birthday 51 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Catonsville, Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME James E. Dubel
14. MOTHER'S MAIDEN NAME Susie Agusta Minnick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT J Edward Smith.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

170 Immediate cause (a) Carcinoma of breast

50 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) metastases to spine, skull etc.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 10, 1948, to April 2, 1949, that I last saw the deceased alive on March 10, 1949, and that death occurred at 7:55 a.m., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson, M.D. (Degree or title) ADDRESS Lothian, Md. DATE SIGNED 4/4/49

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ DATE Apr. 4, 1949 NAME OF CEMETERY OR CREMATORY Quaker Cem LOCATION (City, town, or county) Galesville A.A. Co. (State) Md

DATE REC'D BY LOCAL REG. Mar. 4th 1949 REGISTRAR'S SIGNATURE J.M. Clayton Reg Local
24. FUNERAL DIRECTOR H.A. Hardisty & Son ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03453

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosptial

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville, Maryland
STREET ADDRESS (If rural, give location) Galesgille P.O.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	John	William	SMITH		April	16,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Married	June 18, 1882	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Capt. Small Craft
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Galesville, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Smith
14. MOTHER'S MAIDEN NAME: Betty Wayson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Isabel Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151 46 lb

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral thrombosis

(c) Hypertensive Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 1949, to April 16, 1949, that I last saw the deceased alive on April 16, 1949, and that death occurred at 11:30 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
E Lunt Lusk	M D	3 Chesapeake at	Easypart Maryland.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	4-19-49	Chirst Church Cemetery	Owensville, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
April 18, 1949	[signature]	B.L. Hopping and Son	Annapolis, Md.

RECEIVED
APR 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03454

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 34 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arun.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural, give location) not known

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) (Last) Sway
4. DATE OF DEATH (Month) (Day) (Year) 4/16/49 19

5. SEX female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH Oct. 1868 ~~not known~~
9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Alexander Howard
14. MOTHER'S MAIDEN NAME Mary Ellen Rideout

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~(If yes, give war or dates of service)~~
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemmorrhage	known since 4/14/49
Antecedent cause(s)	(b) Generalized Arteriosclerosis	known since ten years
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Paranoid Condition	known since admission

331

83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/24/15 19....., to 4/16/49, 19....., that I last saw the deceased alive on 4/16/49, 19....., and that death occurred at 6:40 P.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Hengerstern M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 4/16/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4/23/49
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) (State) Annapolis, Md

DATE REC'D BY LOCAL REG. 4/22/49
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John B. Johnson ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 25 1949
BUREAU Y. S.

03455

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
LENGTH OF STAY (In this place) 27 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Elie (Middle) (Last) Tongue

4. DATE OF DEATH: (Month) April (Day) 26 (Year) 49

5. SEX: Male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3/4/77

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: JERRY TONGUE

14. MOTHER'S MAIDEN NAME: MARY OFFER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Gus tongue

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral thrombosis

332 Antecedent cause(s)

838 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis - hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-26-, 1949, to 4-26-, 1949, that I last saw the deceased alive on 4-20, 1949, and that death occurred at 10.10 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Emily H. Wilson, M.D. Lothian, Md. 4/28/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) burial | DATE April 29 1949 | NAME OF CEMETERY OR CREMATORY Daniel Star | LOCATION (City, town, or county) West River (State) Md.

DATE REC'D BY LOCAL REG. 4/29/49 | REGISTRAR'S SIGNATURE O.M. Clayton Deputy Reg | 24. FUNERAL DIRECTOR T.A. Hardesty & Son ADDRESS Gales

RECEIVED
MAY 2 1949
BUREAU V. S.

03456

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Revell Sta., nr. Arnold.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Unknown COUNTY Unknown
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Undetified (Middle) Infant (Last)

4. DATE OF DEATH (Month) Apr. (Day) 30 (Year) 1949

5. SEX female
6. COLOR OR RACE probably white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH unknown
9. AGE last birthday yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

983 Immediate cause (a) Infanticide

165 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Body found in woods, near Revell Station Apr. 30, 1949.

(c) Had been placed there in small carrying case which had evidently been torn open by some animal and part of body eaten. 3 pieces of skull and both arms were missing. Intercostal muscles were also eaten. Internal organ were also missing.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 5/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 5-3-49 NAME OF CEMETERY OR CREMATORY A.A. Co. Cemetery LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. May 2, 1949 REGISTRAR'S SIGNATURE [signature] Trench
24. FUNERAL DIRECTOR B. L. Hopping & Son ADDRESS Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
MAY 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

03457

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Michigan COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Detroit
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Benjamin (Middle) Harrison (Last) WANNAMAKER
4. DATE OF DEATH: (Month) 4 (Day) 26 (Year) 1949
5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)
8. DATE OF BIRTH: April 1884
9. AGE last birthday: Unknown about 65 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): News Paper writer
10b. KIND OF BUSINESS OR INDUSTRY: News Paper
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: L. G. Wannamaker

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

819.5 **Immediate cause** (a) Crushed Chest

170 c **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Compound Fracture left leg & right ankle

(c) Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office building, etc.) OF INJURY Route 301 (CITY OR TOWN) near Millersville (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Apr. (Day) 26 (Year) 1949 (Hour) 3:00 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Truck collided with tree.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Lafly M.D. Deputy Medical Examiner Annapolis, Md 4/26/49

23. BURIAL, CREMATION, REMOVAL (Strike out) DATE THEREOF April 28th 1949 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) Scottville (State) Michigan

DATE REC'D BY LOCAL REG. April 28, 1949 | REGISTRAR'S SIGNATURE Wm. A. Arnold

24. FUNERAL DIRECTOR John M. Taylor, Son ADDRESS Annapolis Md.

+ 881
99
674

RECEIVED
APR 30 1949
BUREAU P. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03458

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest TOWN) Annapolis; MARYLAND; LENGTH OF STAY (In this place) dead on arrival; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) 1113 Carson Court

3. NAME OF DECEASED (Type or Print): (First) Abraham (Middle) (Last) Watkins

4. DATE OF DEATH: (Month) 4 (Day) 8 (Year) 1949

5. SEX: male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: april 2 1915

9. AGE last birthday: 34 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wheeler Watkins

14. MOTHER'S MAIDEN NAME: Fannie Lane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Pearl Fenwick 577 Pressman St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Crushed Chest

910.3 Antecedent cause(s)

195d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Punctured lungs

(c) Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Lake High School; (CITY OR TOWN): Annapolis; (COUNTY): A.A.; (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Apr. 8 1949 12:40 p.m.

INJURY OCCURRED While at Work ☑ Not While At work ☐

HOW DID INJURY OCCUR? Hit by bucket of steam shovel when gear broke and released it falling on him

22. I hereby certify that I ~~attended the deceased from....., 19....., to~~ made a Postmortem Examination Apr. 8, 1949, ~~that I last saw the deceased alive on....., 19.....~~ and that death occurred at 1:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): John R. Leffy M.D., Deputy Medical Examiner; ADDRESS: Annapolis. Maryland; DATE SIGNED: 4/18/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE: 4-13-49; NAME OF CEMETERY OR CREMATORY: Mt Auburn; LOCATION (City, town, or county): Md (State)

DATE REC'D BY LOCAL REG.: 4/18/49; REGISTRAR'S SIGNATURE: A W. Hedrick Jr.

24. FUNERAL DIRECTOR: George D. Kelson; ADDRESS: 1303 Pressman St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for addition in #18-part 1 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03459

FILM No. G 1[illegible] MAY 25 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 11 Monument St

3. NAME OF DECEASED (Type or Print) (First) Bertha (Middle) (Last) Natkin
4. DATE OF DEATH (Month) April (Day) 4 (Year) 1949
5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 12-25-1900
9. AGE last birthday 48 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Woods
14. MOTHER'S MAIDEN NAME Sadonia Matthew
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Annie Harris

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491 Immediate cause (a) Pneumonia, Broncho 5/24/49 ams.

107 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Annapolis (COUNTY) aa (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1, 1949, to 4-3, 1949, that I last saw the deceased alive on 4-3, 1949, and that death occurred at 5:30 p m., from the causes and on the date stated above.

SIGNATURE P. Alley (Degree or title) an D ADDRESS 10 Carroll DATE SIGNED 4-6-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 4-7-1949
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) Annapolis (State) Md.
DATE REC'D BY LOCAL REG. April 7, 1949
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR William Reese, II - 108 Washington St. Annapolis, Md. ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 8 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03460

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Ridge
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 River Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Ridge
STREET ADDRESS (If rural give location) 90 River Drive

3. NAME OF DECEASED (Type or Print) (First) JESSIE (Middle) McLEISH (Last) WATSON

4. DATE OF DEATH (Month) (Day) (Year) April 20, 1949 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH July 21, 1865
9. AGE last birthday 83 yrs. If under 1 year Months 8 Days 29 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian
10b. KIND OF BUSINESS OR INDUSTRY U.S.Cong. L.
11. BIRTHPLACE (State or foreign country) St. Paul, Minnesota
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Watson
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT Miss Mary Irene Roeth

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
443 Immediate cause	(a) Myocardiopis & Myocardial Insufficiency	Several years
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis Generalized	
	(c) Hypertension	10 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1949, to April 20, 1949, that I last saw the deceased alive on April 20, 1949, and that death occurred at 11 a m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 4.21.49

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 4-21,-49
NAME OF CEMETERY OR CREMATORY To
LOCATION (City, town, or county) (State) Northfield, Minnesota

DATE REC'D BY LOCAL REG. April 21, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Maryla

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APR 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 03461

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Balt. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 4 yrs. 11 mos.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 559 Bloom Street

3. NAME OF DECEASED (Type or Print)	(First) Belle	(Middle)	(Last) West	4. DATE OF DEATH	(Month) 4/21/49 (Day) (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated	8. DATE OF BIRTH: not known 1906	9. AGE last birthday: 43(?) yrs.	If under 1 year: ~~Months~~ ~~Days~~ If under 24 hrs.: ~~Hours~~ ~~Min.~~
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): South Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: Harrison Williams	14. MOTHER'S MAIDEN NAME: Ella Tillmen				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculosis of the left hip joint	known to us since 12/5/47
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Simple Type	known to us since 5/16/46

012.1

17 b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/16/46, 19....., to 4/21/49, 19....., that I last saw the deceased alive on 4/21/49, 19....., and that death occurred at 6:45 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Md.	4/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 4/25/1949	NAME OF CEMETERY OR CREMATORY: Mt. Auburn	LOCATION (City, town, or county) (State): Baltimore, Md.
DATE REC'D BY LOCAL REG.: 4/25/49	REGISTRAR'S SIGNATURE: G. W. Hedrick Dm	24. FUNERAL DIRECTOR: Mrs. Geo. H. Holland	ADDRESS: 1630 Druid Hill Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03462

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Julia (Middle) (Last) Willis

4. DATE OF DEATH (Month) April (Day) 22 (Year) 1949

5. SEX female

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH July 11, 1880

9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Mississippi

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gabriel Major

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Carrie H. Thompson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Acute cardiac failure	sudden
93d Antecedent cause(s)	(b) Cardio-vascular disease	not known
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arterio-sclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination ~~19~~ to Apr. 22, 1949, ~~that I last saw the deceased~~ ~~alive on~~ ~~19~~, and that death occurred at 7.15 A.m. from the causes and on the date stated above.

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis - Maryland DATE SIGNED 4/22/49

23. BURIAL, CREMATION REMOVAL (Specify) DATE Apr 25-49 NAME OF CEMETERY OR CREMATORY Franklin Cem LOCATION (City, town, or county) Churchton (State) Md

DATE REC'D BY LOCAL REG. April 24-49 REGISTRAR'S SIGNATURE I. B. Dent

24. FUNERAL DIRECTOR F. A. Hardisty & Son ADDRESS Galesville Md.

RECEIVED
APR 26 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03463

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Ann Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Intersection Defense and Crane Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL and give uearest town) OR TOWN Naval Air Station, Patuxent River, Md.
STREET ADDRESS (If rural give location) Naval Air Station, Patuxent River, Md.

3. NAME OF DECEASED (Type or Print) (First) Howard (Middle) George (Last) Wockenfuss

4. DATE OF DEATH (Month) April (Day) 22nd (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 2-16-25
9. AGE last birthday 24 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy
10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Louis Wockenfuss
14. MOTHER'S MAIDEN NAME Harriett Hueller (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW#2.
16. SOCIAL SECURITY NO.
17. INFORMANT Navy Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Contusion, Brain, Extensive.

825.5 Antecedent cause(s)

170 c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Injuries, Multiple, Extreme

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street (CITY OR TOWN) Rural- Annapolis (COUNTY) Ann Arundel (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) April 22 1949 12am App. m.
INJURY OCCURRED While at Work ☐ Not While At work ☒
HOW DID INJURY OCCUR? Automobile Accident

Pronounced dead on arrival at U.S. Naval Hospital, Annapolis, Md. at about 1pm 4-22-49.

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE John M. Cleffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 4/23/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 4-26-49 NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery LOCATION (City, town, or county) Violetsville (State) Md

DATE REC'D BY LOCAL REG. 4/26/49 REGISTRAR'S SIGNATURE Ch. Hedrick
24. FUNERAL DIRECTOR F. B. Wippert & Son ADDRESS 1300 Eutaw Pl 17

03464

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown; STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Franklin (Last) Willard Jr

4. DATE OF DEATH: (Month) Apr. (Day) 29 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: 26 June 1926

9. AGE last birthday: 22 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Soldier

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James F Willard

14. MOTHER'S MAIDEN NAME: Daisy Pleasant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: U.S.A. Rm 4 Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fracture of Skull

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Crushed Chest

(c) Accidental

819.5 170c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office building, etc.): Route 301; (CITY OR TOWN) near Millersville; (COUNTY) A.A.; (STATE) Md.

TIME OF INJURY: (Month) Apr. (Day) 28 (Year) 1949 (Hour) 11 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Automobile Accident

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE: John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 4/29/49

23. BURIAL, CREMATION, REMOVAL (Specify): Removal; DATE THEREOF 29 Apr 49; NAME OF CEMETERY OR CREMATORY Rest Haven; LOCATION (City, town or county) Hagerstown; (State) Md.

DATE REC'D BY LOCAL REG. 29 Apr 49; REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR: Talty & Zeller, Inc. ADDRESS Baltimore Md

RECEIVED
MAY 9 1949
BUREAU V. S.